DEP-DP DISEASE PROCESS

OUTCOME: The patient and/or family will understand the psychological and physiological causes major depression.

STANDARDS:

1. Discuss the common symptoms of major depression with the patient and/or family:
   a. Persistent sadness lasting longer than two weeks
   b. Loss of interest in usual activities
   c. Weight loss or gain
   d. Sleep disturbances
   e. Energy loss
   f. Fatigue
   g. Hyperactive or slowed behavior
   h. Decreased or slowed sexual drive
   i. Feelings of worthlessness
   j. Difficulty concentrating or making decisions
   k. Recurrent suicidal thoughts **See SB**
   l. Memory loss

2. Assure the patient and/or family that prognosis is usually good, with appropriate treatment.

3. Stress that many episodes of depression are not preventable. Treatment, including medications and psychiatric intervention, may prevent recurrences.

4. Discuss that antidepressant drug therapy combined with psychotherapy appears to have better results than either therapy alone.

DEP-EX EXERCISE

OUTCOME: The patient will understand the importance of exercise as a part of treatment plan.

STANDARDS:

1. Explain that moderate exercise may increase energy, improve circulation, enhance sleep, and reduce stress and depression.

2. Encourage a program of regular exercise for optimal benefit.

DEP-FU FOLLOW-UP

OUTCOME: The patient and family will understand the importance of treatment plan compliance and regular follow-up.

STANDARDS:

1. Discuss the patient's responsibility in managing major depression.

2. Review the treatment plan with the patient/family, emphasizing the need for keeping appointments and adhering to medication regimens.

3. Instruct the patient/family to contact a mental health professional or other medical personnel if persistent thoughts of suicide occur.

4. Explain the process for making follow-up appointments.

DEP-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about major depression.

STANDARDS:

1. Provide the patient/family with written patient education literature on major depression.

2. Discuss the content of the patient education literature with the patient/family.

DEP-M MEDICATIONS

OUTCOME: The patient/family will understand the proper use of antidepressant medication.

STANDARDS:

1. Review the mechanism of action of the prescribed medication.

2. Discuss proper use, benefits and common side effects of prescribed medications.

3. Explain that some medications may have long-term effects that require regular monitoring and follow-up.

4. Discourage the use of alcohol and recreational drugs.

5. Explain that it may be six weeks before the antidepressant medication takes effect.

6. Explain that drug therapy may include one or a combination of tricyclic antidepressants, monoamine oxidase inhibitors and serotonin re-take uptake blockers or psychotropic medications that work by other mechanisms.

7. Discuss the risks associated with the medications especially in overdoseage. All medications should be stored in a safe place in child-resistant containers.

8. Discuss drug/drug and drug/food interactions as applicable.

DEP-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy.

STANDARDS:

1. Emphasize that for the process of psychotherapy to be effective the patient must keep all appointments.

2. Emphasize the importance of openness and honesty with the therapist.

3. Explain to the patient that the therapist and the patient will establish goals, ground rules, and duration of therapy.

DEP-WL WELLNESS

OUTCOME: The patient/family will understand some of the factors which contribute to a balanced and healthy lifestyle.

STANDARDS:

1. Explain that a healthy diet is an important component of emotional health.

2. Emphasize the importance of stress reduction and exercise in emotional health.

3. Refer the patient/family to support groups as appropriate.

DM-C COMPLICATIONS

OUTCOME: The patient/family will understand common or serious complications of uncontrolled blood sugar.

STANDARDS:

1. Emphasize that the end-organ damage (kidney failure, blindness, heart attack, impotence, limb amputations, etc.) results directly from high blood sugar and that the goal of management is to keep blood sugar as near to normal as possible.

2. Emphasize that good control of blood sugar can dramatically reduce the risk of complications and end-organ damage.

3. State that Type 2 DM is a chronic disease that needs to be monitored for complications. Routine examinations are essential.

4. Discuss common complications of uncontrolled high blood sugar (blindness, impotence, increased yeast infections, increased urinary tract infections, kidney failure, loss of limbs, heart attack, stroke, early death, etc.).

5. Explain that patients with Type 2 DM are at high risk for infectious diseases. Review the current recommendations for immunizations and refer for immunization as appropriate. Refer to **IM.**

6. Explain that patients with Type 2 DM are at high risk for visual loss. Review the current recommendations for eye examinations and refer to appropriate heath-care providers. Refer to **ODM.**

7. Explain that uncontrolled blood sugar can result in small-vessel damage in the heart which leads to heart attacks and cannon usually be treated. Explain that Type 2 DM also worsens atherosclerotic disease which can also lead to heart attacks and strokes. Refer to **CVA, CAD,** and **PVD.**

DM-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of Type 2 DM.

STANDARDS:

1. Briefly describe the pathophysiology of Type 2 DM, including the concept of insulin resistance.

2. Emphasize that the end-organ damage (kidney failure, blindness, heart attack, impotence, limb amputations, etc.) results directly from high blood sugar and that the goal of management is to keep blood sugar as near to normal as possible.

3. Describe risk factors for development and progression of Type 2 DM (family history, obesity, high intake of simple carbohydrates, sedentary lifestyle, etc.).

4. Describe feelings/symptoms which the patient may experience when blood sugar is high (increased thirst, increased urination, lethargy, headache, blurry vision, impaired concentration, etc.).

5. Emphasize that Type 2 DM is a chronic, controllable condition which requires permanent lifestyle alterations and continuous attention and medical care. Refer to **DM-LA.**

DM-EQ EQUIPMENT

OUTCOME: The patient/family will understand the home management and self-care activities necessary to control blood sugar and make a plan to integrate these activities into daily life.

STANDARDS:

1. Discuss the specific components of this patient's home glucose monitoring and/or home blood pressure monitoring and/or home ketone monitoring and/or home insulin pumps.

2. Demonstrate and receive return demonstration of home glucose monitoring and/or the use of other home equipment.

3. Explain that home glucose monitoring (when prescribed) is a tool to assist the patient in home management of blood sugar.

4. Discuss the importance of logging home glucose readings and insulin administration and emphasize the importance of bringing the record to all medical appointments.

5. Emphasize the importance of home blood pressure monitoring as appropriate.

DM-EX EXERCISE

OUTCOME: The patient/family will understand the relationship of physical activity in achieving and maintaining good blood sugar control and will make a plan to increase regular activity by and agreed-upon amount.

STANDARDS:

1. Explain that regular aerobic exercise will reduce the body's resistance to insulin.

2. Explain that the goal is at least 20-30 minutes of aerobic exercise (such as vigorous walking) at least 5 times per week. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.

3. Assist the patient in developing a personal exercise plan. Refer to **WL-EX.**

4. Discuss obstacles to a personal exercise plan and solutions to those obstacles.

DM-FTC FOOT CARE AND EXAMINATIONS

OUTCOME: The patient/family will understand the risks of skin breakdown, ulcers, and lower extremity amputation associated with Type 2 DM and develop a plan for blood sugar control and regular foot care to prevent these complications.

STANDARDS:

1. Emphasize that even a minor injury to the foot can result in amputation. Stress that wounds do not heal properly if blood sugar is elevated.

2. Demonstrate the proper technique for a daily home foot check by patient or support person.

3. Discuss "dos and don'ts" of diabetic foot care (don't go barefoot, wear appropriate footwear, don't trim you own nails, etc.).

4. Discuss the relationship between peripheral vascular disease, neuropathy, and high blood sugar. Explain that the progression to amputation is typical without early and appropriate intervention. Refer to **PVD.**

5. Emphasize the importance of footwear which is properly fitted for patient with diabetes. Refer for professional evaluation and fitting as appropriate.

6. Remind the patient to remove shoes for each clinic visit.

7. Emphasize the importance of a regularly scheduled detailed foot exam by a trained health care provider.

DM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the prevention of complications and progression and will develop a plan to make and keep follow-up appointments.

STANDARDS:

1. Emphasize the importance of early intervention to prevent complications.

2. Explain that since blood sugar control is critical, regular medical appointments are necessary to adjust treatment plans and prevent complications.

3. Explain that the home glucose monitoring log is an essential part of formulating the treatment plan and must be brought to every appointment.

4. Explain that since Type 2 DM is a chronic condition which affects the entire body, total care is essential. Emphasize the importance of keeping appointments with all health care providers (dental, eye care, foot care, laboratory, etc.).

5. Discuss the procedure for making appointments.

DM-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management and self-care activities necessary to control blood sugar and make a plan to integrate these activities into daily life.

STANDARDS:

1. Discuss the specific components of this patient's home management (nutrition, exercise, home glucose monitoring, self-administration of insulin, taking medications, etc.).

2. Demonstrate and receive return demonstration of home glucose monitoring and/or insulin administration as appropriate.

3. Describe proper storage, care and disposal of medicine and supplies.

4. Explain that home glucose monitoring (when prescribed) is a tool to assist the patient in home management of blood sugar.

5. Discuss the importance of logging home glucose readings and insulin administration and emphasize the importance of bringing the record to all medical appointments.

6. Emphasize the importance of daily foot checks and appropriate foot care. Refer to **DM-FTC.**

7. Emphasize the importance of good personal and oral hygiene. Refer to **WL-HY**.

8. Emphasize the importance of nutritional management. Refer to dietician or other local resources as appropriate.

DM-KID KIDNEY DISEASE

OUTCOME: The patient/family will understand the risks of kidney damage and end-stage renal disease resulting in dialysis associated with Type 2 DM and develop a plan for blood sugar control and regular medical examinations to prevent these complications.

STANDARDS:

1. Emphasize that high blood sugar results in damage to the kidneys. This may result in renal failure requiring long term dialysis or kidney transplant. Once kidney damage occurs it cannot be reversed.

2. Emphasize the need for regular urine analysis and blood chemistry screening.

3. Emphasize that high blood pressure worsens diabetic kidney disease. Reinforce the importance of regular blood pressure screening and taking antihypertensive medications as prescribed. Refer to **HTN.**

DM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about Type 2 DM.

STANDARDS:

1. Provide the patient/family with written patient information on Type 2 DM.

2. Discuss the content of the patient information with the patient/family.

DM-LA LIFESTYLE ADAPTATION

OUTCOME: The patient/family will understand that the most important component in control of high blood sugar is the patient's lifestyle adaptations and will develop a plan to achieve optimal blood sugar control.

STANDARDS:

1. Emphasize that diet and exercise are the critical components of blood sugar control and medical therapies can at best supplement diet and exercise.

2. Emphasize that the end-organ damage (kidney failure, blindness, heart attack, impotence, limb amputations, etc.) results directly from high blood sugar and that the goal of management is to keep blood sugar as near to normal as possible.

3. Explain that the longer the blood sugar is elevated, the greater the damage will be.

4. State the reasons for blood glucose monitoring – to keep track of the level of blood sugar and permit rapid changes necessary to keep sugar under control.

DM-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen.

STANDARDS:

1. Explain that diet and exercise are the key components of control of Type 2 DM and that medication(s) may be prescribed as a supplement to diet and exercise.

2. Describe the proper use, benefits, and common or important side effects of the patient's medication(s). State the name, dose, and time to take pills and/or insulin.

3. For patients on insulin, demonstrate steps in insulin administration. Describe proper storage, care and disposal of medicine and supplies.

4. Reinforce the need to take insulin and other medications when sick and during other times of stress.

5. Emphasize the importance of strict adherence to the medication regimen. Explain that many medications for Type 2 DM do not exert an immediate effect and must be used regularly to be effective.

6. Briefly explain the mechanism of action of the patient's medications as appropriate.

7. Discuss any significant drug/drug or food/drug interactions, including interaction with alcohol.

8. Discuss the signs, symptoms and appropriate actions for hypoglycemia.

DM-N NUTRITION

OUTCOME: The patient/family will understand the importance of nutritional management in the control of blood sugar and develop a plan to meet nutritional goals.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and responsible eating.

2. Review the food pyramid and its role in meal planning. Refer to dietician or other local resources as appropriate.

3. Emphasize the importance of reading food labels. Instruct the patient/family as necessary.

4. Discuss the merits of various food preparation methods (broiling or baking is preferred over frying, avoid gravies and sauces, rinsing or blotting excess grease, etc.).

5. Emphasize the importance of appropriate serving sizes.

6. Emphasize that extra caution or planning is required when eating out, using USDA commodities, or going to special events since these foods are usually high in fat and sugar and serving sizes are often inappropriately large.

7. Emphasize that complex carbohydrates and low-fat proteins are preferred and that sugars and fats should be limited.

DM-P PREVENTION

OUTCOME: The patient/family will understand major risk factors for development of Type 2 DM and will develop a plan for risk reduction.

STANDARDS:

1. Discuss the role of obesity in the development of Type 2 DM.

2. Emphasize that to maintain health and prevent diabetes, extra commitment is necessary for people with a family and/or gestational history of Type 2 DM.

3. Explain that following the food guide pyramid and maintaining adequate activity levels will reduce the risk of getting Type 2 DM.

4. Explain that many people have Type 2 DM for as much as 5-7 years before diagnosis, and that end-organ damage is occurring during that time. Emphasize the importance of regular screening. Discuss current recommendations for screening.

5. Explain that the child of a mother who had high blood sugar during pregnancy is at greatly increased risk for development of Type 2 DM. Emphasize that family planning, pre-conception screening, and early prenatal care can significantly reduce this risk.

DM-PM PAIN MANAGEMENT

OUTCOME: The pateint/family will understand the importance of appropriate management of pain.

STANDARDS:

1. Explain that lower extremity pain may be significant for complications associated with neuropathy which needs to be discussed with the medical provider.

2. Explain that the use of over the counter medications for chronic pain management needs to be assessed by the medical provider to minimize risk to kidney function.

3. Explain that all chest pain must be evaluated by the medical provider to rule out the possibility of myocardial infarction.

DM-WC WOUND CARE

OUTCOME: The patient/family will have an understanding of the necessity and procedure for proper wound care. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the reasons to care appropriately for the wound; decreased infection rate, improved healing, etc.

2. Explain the correct procedure for caring for this patient's wound.

3. Explain signs or symptoms that should prompt immediate follow-up; increasing redness, purulent discharge, fever, increased swelling/pain, etc.

4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.

5. Emphasize the importance of follow-up.

DIA-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient will have a basic understanding of where the kidneys are and their overall function.

STANDARDS:

1. Explain that the normal human body has two kidneys located on either side of the spine just slightly below the ribcage. Each kidney weighs about a quarter of a pound and is the size of a fist. The shape is similar to that of a kidney bean.

2. Discuss that the kidneys help the body maintain fluid levels and assist in regulating blood pressure. In addition, a variety of other chemicals are produced and released by the kidneys so that a balance is always maintained.

3. Review the four major functions of the kidneys, elimination of waste products through an internal blood filtering system, regulation of blood formation and red blood cell production, regulation of blood pressure, and control of the body's chemical and fluid balance.

DIA-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with dialysis and with the decision not to have dialysis.

STANDARDS:

1. Explain that infections are common in dialysis patients and that the patient/family should report all elevations in body temperature to the dialysis staff. Infection, particularly at the site may require immediate hospitalization for IV antibiotic therapy.

2. Explain that deviations from prescribed dietary and fluid restrictions may result in acute metabolic problems, which must be addressed by the dialysis unit.

3. Explain that even with proper dialysis, patients may experience fluid imbalances and that all shortness of breath, unusual swelling, dizziness, etc. should prompt immediate medical evaluation.

DIA-DP DISEASE PROCESS

OUTCOME: The patient/family will verbalize understanding of the causes associated with his/her end stage renal disease.

STANDARDS:

1. Explain that End Stage Renal Disease usually results from long term or prolonged medical conditions such as hypertension or diabetes.

2. Chronic kidney failure may also be the result of heredity such as polycystic disease.

3. At present there is no known cure for chronic kidney disease, however dialysis or transplantation are treatment options.

DIA-EQ EQUIPMENT

OUTCOME: The patient/family/caregiver will understand the purpose, use, and care associated with the patient's prescribed dialysis regimen.

STANDARDS:

1. Discuss the indications for and benefits of prescribed medical equipment.

2. Discuss and/or demonstrate proper use and care of medical equipment; participate in return demonstration by patient/family/caregiver as appropriate.

3. Discuss signs of equipment malfunction and proper action in case of malfunction.

4. Emphasize the safe use of equipment, including infection control measures. Explain that equipment tubing is designed for a single use.

5. Discuss proper disposal of associated medical supplies.

DIA-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the importance of adherence to the treatment regimen and appropriate follow-up and coordination with all health care providers.

STANDARDS:

1. Discuss the individual's responsibility in the management of end stage renal disease including the responsibility to keep all health care providers informed of changes to the treatment plan.

2. Review the treatment plan with the patient/family/caregiver, emphasizing the importance of follow-up care.

3. Discuss the procedure for obtaining follow-up appointments and the procedure for obtaining emergent care appointments.

DIA-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family/caregiver will receive written information regarding the specific type of dialysis the patient is currently receiving, i.e. hemodialysis or peritoneal dialysis.

STANDARDS:

1. Provide the patient/family/caregiver with written patient information literature on specific mode of dialysis.

2. Discuss the content of patient information literature with the patient/family/caregiver.

DIA-M MEDICATION

OUTCOME: The patient/family/caregiver will understand the medications used in the management of the patient's end stage renal disease.

STANDARDS:

1. Explain the medications to be used by this patient including the dosage, timing, proper use and storage of the medication, important and common side effects of the medication including drug/drug and drug/food interactions.

2. Discuss with patient/family/caregiver the need to review all over the counter medications and herbal products prior to use with the dialysis unit pharmacy staff.

3. Discuss medications which may be used during dialysis and the common or important complications which may result.

4. Explain that the patient's medications may change after starting dialysis. Emphasize the importance of bringing all medications to medical appointments.

DIA-N NUTRITION

OUTCOME: The patient/family will verbalize an understanding of the specific prescribed dietary regimen as it relates to their ongoing dialysis.

STANDARDS:

1. Each diet is individualized, however typical dietary restrictions may include calories, fluids, protein, sodium, potassium, calcium and phosphorus.

2. Refer to a Registered Dietician as appropriate.

DIA-PRO PROCEDURES

OUTCOME: The patient/family will verbalize understanding of the proposed procedure(s), as well as the risks, benefits, alternatives to the proposed procedure(s) and associated factors affecting the patient.

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events which might result from refusal of the procedure.

2. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.

3. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

DCH-EQ EQUIPMENT

OUTCOME: The patient/family will verbalize understanding and demonstrate (when appropriate) proper use and care of home medical equipment provided at hospital discharge.

STANDARDS:

1 Discuss indications for and benefits of prescribed home medical equipment.

2 Discuss types and features of home medical equipment as appropriate.

3 Discuss and/or demonstrate proper use and care of home medical equipment, participate in return demonstration by patient/family.

4 Discuss signs of equipment malfunction and proper action in case of malfunction.

5 Emphasize safe use of equipment i.e. no smoking around O2, use of gloves, electrical cord safety, disposal of sharps).

6 Discuss proper disposal of associated medical supplies.

DCH-FU FOLLOW UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep scheduled follow-up appointments after discharge.

STANDARDS:

1 Discuss the importance of follow-up care following hospitalization.

2 Discuss the procedure for obtaining follow-up appointments.

3 Emphasize the importance of keeping appointments.

DCH-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of their disease processes following hospital discharge and make a plan for implementation.

STANDARDS:

1 Discuss the home management plan and methods for implementation of the plan.

2 Explain the importance of following a home management plan, i.e. fewer complications, fewer falls/injuries, etc.

3 Explain the use and care of any necessary home medical equipment.

DCH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information regarding their discharge plans including medical therapies, follow up appointments, and contact information.

STANDARDS:

1 Provide patient/family with written patient information regarding their discharge plans including:
   a. Medical therapies prescribed
   b. Follow up appointments
   c. Follow up lab work
   d. Assessments required
   e. Cautions regarding the discharge plans
   f. Contact information

2 Discuss the discharge plan with the patient/family.

DCH-LA LIFESTYLE ADAPTATION

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of the disease state or condition or to improve mental or physical health following hospital discharge.

STANDARDS:

1 Review lifestyle aspects/changes that the patient has control over - nutrition, exercise, safety, and injury prevention, avoidance of high risk behaviors, and participation in the treatment plan.

2 Emphasize that an important component in the prevention or treatment of disease is the patient's adaptation to a healthier, lower risk lifestyle.

3 Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

DCH-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1 Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.

2 Discuss the importance of following the medical regimen.

3 Discuss the importance of informing your providers and pharmacists of any allergies or adverse medication reactions that you may have experienced.

4 Discuss the importance of being able to identify any discharge medications.

5 Discuss the importance of being able to take the appropriate amount of medication. Ensure dosage forms can be obtained (i.e: breaking tablets in half or using a pill cutter) and that appropriate measuring devices (oral syringes, droppers) are provided and instruction on their use given.

DCH-N NUTRITION

OUTCOME: The patient will verbalize understanding of the need for balanced nutrition and plan for the implementation of dietary modification following hospital discharge if needed.

STANDARDS:

1 Review nutritional needs for optimal health.

2 Discuss current nutritional habits. Assist patient in identifying unhealthy nutritional habits.

3 Discuss nutritional modifications as related to the specific disease states.

DCH-POC PLAN OF CARE

OUTCOME: The patient/family will have a basic understanding of the discharge plan for care, including the plans for pain management.

STANDARDS:

1 Explain the basic plan of care for the patient, including the following:
   a. Plan for continued home treatment
   b. Anticipated assessments
   c. Tests to be performed, including laboratory tests, x-rays, and others
   d. Therapy to be provided (medication, physical therapy, dressing changes, etc.)
   e. Advance directives
   f. Plan for pain management
   g. Nutrition and dietary plan including restrictions if any
   h. Follow-up plans

DCH-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure, including indications, complications, and alternatives, as well as possible results of non-treatment.

STANDARDS:

1 Discuss the indications, risks, and benefits and alternatives for the proposed procedure(s) as well as the risk of not undergoing the procedure.

2 Explain the process and what to expect after the procedure.

3 Discuss pain management as appropriate.

4 Emphasize post-procedure management and follow-up.

5 Discuss procedure findings and implications as appropriate.

DCH-REF REFERRAL

OUTCOME: The patient/family will understand the referral process and financial responsibilities.

STANDARDS: Choose from the following standards as appropriate.

1 Emphasize that referrals to outside providers by Indian Health Service primary providers typically will be processed by Contract Health Services.

2 Explain the procedure for the referral to the private sector is usually based on a priority system and/or waiting list..

3 Explain that coverage by insurance companies and Medicare/Medicaid packages will be utilized prior to utilizing contract health service funds in most cases. The Indian Health Service is a payer of last resort.

4 Discuss the rules/regulations of Contract Health Services.

5 Refer as appropriate to community resources for Medicaid/Medicare enrollment, i.e. Benefits Coordinator.

6 Discuss the importance of follow-up care and the requirement to notify contract health services of any future appointments and procedures by the private sector. **Referrals are for one visit only** (unless otherwise specified.) Future and/or additional referrals must be approved prior to the appointment.

DCH-RI PATIENT RIGHTS AND RESPONSIBILITIES

OUTCOME: The patient/family will have a basic understanding of their rights and responsibilities as well as the process for conflict resolution.

STANDARDS:

1 Discuss the patient's responsibility to follow the agreed upon plan of care and to keep follow-up appointments.

2 Briefly explain the process for resolving conflicts if the patient/family believe that their rights have been violated.

3 Discuss availability of cultural/spiritual/psycho social services that may be available as appropriate.

DCH-S SAFETY

OUTCOME: The patient/family will have an understanding of the necessary precautions to prevent injury following hospital discharge.

STANDARDS:

1 Discuss the mutually agreed upon plan of care for safety based on the patient-specific risk assessment.

2 Emphasize safe use of equipment. **See DCH-EQ**

DCH-TE TESTING

OUTCOME: The patient/family will have an understanding of the test(s) to be performed at the time of or following hospital discharge including indications and its impact on further care.

STANDARDS:

1 Explain the test(s) ordered.

2 Explain the necessity, benefits, and risks of the test to be performed.

3 Explain the testing process to help the patient understand what he/she might experience during the test.

4 Explain the meaning of the test results.

DCH-TX TREATMENT

OUTCOME: The patient/family will have an understanding of the possible treatments that may be available based on the specific disease process, test results, and individual preferences.

STANDARDS:

1 Explain that the treatment plan will be made by the patient and medical team after reviewing available options.

2 Discuss the treatment plan including lifestyle adaptations, cultural practices, pharmacologic, and psycho social aspects of the treatment plan.

3 Discuss the importance of participating in the treatment plan, including scheduled follow-up.

4 Refer to community resources as appropriate.

DIV-C COMPLICATIONS

OUTCOME: The patient/family will understand the signs of complications and will plan to return for medical care if they occur.

STANDARDS:

1. Explain that some possible complications of diverticulosis and diverticulitis may include hemorrhage, abscess development and perforation with peritonitis, bowel obstruction, intussusception, and volvulus.

2. Advise the patient to seek immediate medical care for any signs of complications, such as lower abdominal cramping, abdominal distention fever, malaise, hemorrhage.

DIV-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of diverticulitis/diverticulosis.

STANDARDS:

1. Explain that a diverticulum is a pouch or saccular dilatation from the main bowel cavity. Diverticulosis is the condition in which an individual has multiple diverticulae. Diverticulitis is an inflammation of one or more diverticulae.

2. Explain that- some of the- predisposing factors may include congenital predisposition, weakening and degeneration of the muscular wall of the intestine, chronic over distention of the large bowel, and a diet low in roughage.

3. Explain that diverticulosis develops in nearly 50% of persons over age 60, but only a small percentage develops diverticulitis.

4. Explain that diverticulosis-ma-y be accompanied by minor bowel irregularity, constipation and diarrhea.

5. Explain that symptoms of diverticulitis may range from mild abdominal soreness and cramps with "gas" and low grade fever, to more severe cramping and pain accompanied by fever, chills, nausea, abdominal rigidity and massive hemorrhage.

6. Inform the patient that diverticulitis may be acute or chronic.

DIV-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.

2. Discuss the procedure for obtaining follow-up appointments.

3. Emphasize that appointments should be kept.

DIV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about diverticulitis and or diverticulosis.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding diverticulitis and/or diverticulosis.

2. Discuss the content of the patient information literature with the patient/family.

DIV-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen and make a plan to take the medication as prescribed.

STANDARDS:

1. Describe the proper use, benefits, and common or important side effects of the patient's medications. State the name, dose, and time for administration as applicable.

2. Discuss any significant drug/drug or drug/food interactions, including interaction with alcohol.

3. Discuss with the patient/family the need to complete the full course of antibiotics, as prescribed (when indicated.)

4. Caution the patient/family against utilizing over-the-counter medications for constipation without consulting his/her provider.

DIV-N NUTRITION

OUTCOME: The patient/family will have an understanding of how dietary modification may assist in the control of bowel function and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.

2. Emphasize the hazards of constipation.

3. Explain that during periods of acute inflammation, it may be necessary to begin with a very restricted diet and slowly progress to a bland diet.

4. Explain that bulk can be added to stools by eating fruits and vegetables with a high fiber content (seedless grapes, fresh peaches, carrots, lettuce.)

5. Encourage a diet that is high in fiber and low in sugar to maintain intestinal tract function. Advise to avoid indigestible roughage, such as celery and corn.

6. Provide list of appropriate foods that are high in fiber and low in sugar.

7. Advise the patient/family to avoid extremely hot or cold foods and fluids, because they may cause flatulence. Also, alcohol, which irritates the bowel, should be avoided. Stress the importance of thoroughly chewing all foods.

8. Assist the patient/family in developing appropriate meal plans.

9. Stress the importance of water in maintaining fluid balance and preventing constipation.

10. Refer to dietitian as appropriate.

DIV-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of diverticulitis and/or diverticulosis.

STANDARDS:

1. Discuss the effects of a fatty, low fiber diet on the colon.

2. Provide and review a list of low fat, high fiber foods.

3. Assist the patient/family in meal planning that includes low fat, high fiber foods and avoids high fat, low fiber foods.

4. Explain that the etiology of Crohn's disease is unknown and there is no known prevention, but an appropriate diet may prevent or slow progression of the disease.

DIV-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Explain that diverticulitis with pain usually responds to a liquid or bland diet and stool softeners to relieve symptoms, minimize irritation, and decrease the spread of the inflammation.

2. Discuss the plan for pain management during the acute phase, which may include opiate or non-opiate analgesics and anticholinergic to decrease colon spasms.

3. Advise the patient not to use over the counter pain medications without checking with his/her provider.

4. Discuss non-pharmacologic methods of pain control as appropriate.

DIV-TE TESTS

OUTCOME: The patient/family will have an understanding of the tests to be performed.

STANDARDS:

1. Proctosigmoidoscopy and Colonoscopy
    a. Explain that proctosigmoidoscopy and colonoscopy may be utilized to directly visualize the inside of the colon and enable biopsies to be obtained. The information from the colonoscopy may be necessary to diagnose the specific type of bowel disease.
    b. Explain that the procedure involves introducing a flexible tube through the anus and rectum.
    c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.

2. Barium Enema
    a. Explain that the barium enema is an x-ray to assess the extent of the disease, identify lesions, detect pseudo polyps, carcinoma, and strictures.
    b. Explain that barium liquid will be introduced by enema and radiographs taken.
    c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.

DIV-TX TREATMENT

OUTCOME: The patient/family will have an understanding of the prescribed treatment for diverticulitis/diverticulosis and verbalize a plan to adhere to the treatment regimen.

STANDARDS:

1. Discuss the specific treatment plan, which may include the following:
    a. During acute episodes, nothing by mouth and IV fluid and nutritional support may be necessary in order to rest the bowel
    b. Liquid or bland diet during the less acute phase, then a high fiber diet to counteract the tendency toward constipation
    c. Stool softeners
    d. Antimicrobial therapy to combat infection
    e. Antispasmodics to control smooth muscle spasms
    f. Surgical resection of the area of involved colon and sometimes temporary colostomy

2. Advise the patient to avoid activities that raise intra-abdominal pressure, such as straining during defecation, lifting, coughing, etc.

3. Discourage smoking, as it irritates the intestinal mucosa.

DV-DP DISEASE PROCESS

OUTCOME: Patient/family will understand and accept domestic violence dependency as a primary, chronic, and preventable disease.

STANDARDS:

1. Discuss the patient's abusive/violent disorder.
2. Discuss the patient's and family's attitudes toward their dependency.
3. Explain co-dependency as it relates to domestic violence.
4. Identify risk factors and "red flag" behaviors related to domestic violence.
5. Discuss the role of alcohol and substance abuse as it relates to domestic violence.
6. Explain that the natural course of domestic violence is one of escalation and that without intervention it will not resolve.

DV-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments
3. Emphasize that appointments should be kept.

DV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about domestic violence.

STANDARDS:

1. Provide patient/family with written patient information literature on domestic violence.
2. Discuss the content of patient information literature with the patient/family.

DV-P PREVENTION

OUTCOME: Patient and family will have an understanding of risk factors and behaviors which predispose to domestic violence and develop a plan to avoid relationships and situations which may result in domestic violence.

STANDARDS:

1. Explain predisposing risk factors for domestic violence, including a pathological need for control, alcohol and/or substance abuse, history of child abuse and/or domestic violence in the family of origin, etc.

2. Explain that environmental stressors, physiologic changes, and illnesses may precipitate violent behavior in persons who are predisposed to violent behaviors.

3. Discuss the progression of domestic violence from verbal/emotional abuse such as shouting and name-calling to physical violence such as shoving to injury and death.

4. Explain that the natural course of domestic violence is one of escalation and that without intervention it will not resolve.

5. Develop a plan of care to avoid violent relationships.

DV-PSY PSYCHOTHERAPY

OUTCOME: The patient will understand the goals and process of psychotherapy.

STANDARDS:

1. Emphasize that for the process of psychotherapy to be effective they must keep all their appointments. Emphasize the importance of openness and honesty with the therapist.

2. Explain to the patient that the therapist and the patient will jointly establish goals, ground rules, and duration of therapy.

DV-S SAFETY AND INJURY PREVENTION

OUTCOME: Patient, family members, and other victims will understand the pattern of domestic violence, make a plan to end the violence, develop a plan to insure safety of everyone in the environment of violence, and implement that plan as needed.

STANDARDS:

1. Be sure family members and other victims are aware of shelters and other support options available in their area. Make referrals as appropriate.

2. Review co-dependency. See **DV-DP**.

3. Assist to develop a plan of action which will insure safety of all people in the environment of violence.

DV-TX TREATMENT

OUTCOME: The patient and family will understand that domestic violence as a chronic disease will require long-term intervention which may include psychotherapy, medication, and support groups.

STANDARDS:

1. Review the nature of domestic violence as a primary, chronic, and treatable disease.

2. Explain that both patient and family need to acknowledge, admit, and request help.

3. Review treatment options available, including individual, family counseling, group advocacy, etc.

LIP-C COMPLICATIONS

OUTCOME: The patient will have an understanding of the complications of uncontrolled dyslipidemia.

STANDARDS:

1. Review the disease process of atherosclerosis/thrombosis, and how high cholesterol is involved in this process and its involvement in cerebrovascular disease (stroke), cardiovascular disease (heart attack), and peripheral vascular disease.

2. Explain that heart attacks may result due to blocked arteries in the heart.

3. Explain that strokes may result due to blocked arteries in the neck or brain.

4. Explain that leg pain and loss of use of legs may result due to blocked arteries in the legs.

LIP-DP DISEASE PROCESS

OUTCOME: The patient will have an understanding of what causes their dyslipidemia.

STANDARDS:

1. Review the causative factors of dyslipidemia (genetic, DM, thyroid disease, liver disease, kidney disease, drugs, etc.) as appropriate to the patient.

2. Review lifestyle factors which may worsen dyslipidemia (obesity, high saturated fat/carbohydrate intake, lack of regular exercise, tobacco use, alcohol intake).

3. Review factors other than dyslipidemias which predispose toward development of atherosclerotic disease (DM, HTN, low HDL, tobacco use, age, or family history of premature heart disease). Emphasize that dyslipidemias in combination with other risk factors greatly increase the risk of other vascular diseases including heart attacks and strokes.

LIP-EX EXERCISE

OUTCOME: The patient/family will understand the exercise recommendations or limitations for this patient's disease process.

STANDARDS:

1. Discuss the exercise recommendations or limitations of exercise for this patient.

2. Emphasize the importance of seeking medical advise prior to starting/changing any exercise program.

LIP-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of follow-up and will develop a plan to manage their dyslipidemia and to make and keep follow-up appointments.

STANDARDS:

1. Emphasize that the treatment plan and compliance with it are the responsibility of the patient.

2. Encourage the patient to get a fasting lipid profile on a regular schedule, keep appointments, and comply with the therapeutic plan.

LIP-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about dyslipidemia.

STANDARDS:

1. Provide patient/family with written patient information literature on the dyslipidemia.

2. Discuss the content of patient information literature with the patient/family.

LIP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will have an understanding of the lifestyle adaptations necessary to maintain control of dyslipidemia and develop a realistic plan to accomplish this.

STANDARDS:

1. Discuss the importance of regular exercise, weight control, and a reduced fat diet in the control of dyslipidemia

2. Explain that regular aerobic exercise lowers lipid levels and recommend that the patient should start slow and work up to an appropriate exercise level that is recommended by the health care provider.

3. Discuss the importance of cessation of tobacco use in the control of dyslipidemia.

4. Assist the patient to formulate a therapeutic plan which includes stress reduction, diet, exercise, and medications, as indicated.

5. Review the nationally accepted, current lipid reduction goals and assist the patient to establish a personal goal for lipid control.

LIP-M MEDICATIONS

OUTCOME: The patient will have an understanding of the importance of their prescribed medications.

STANDARDS:

1. Briefly review the different classes of lipid lowering drugs.

2. Review the proper use, benefits, and common side effects of these medications.

3. Review the clinical effects expected with these medications.

4. Review medications which adversely affect lipids as appropriate.

LIP-N NUTRITION

OUTCOME: The patient will have an understanding of the interaction between diet and lipid levels and formulate a healthy nutrition plan.

STANDARDS:

1. Explain the basics of the Step I AHA diet for all patients with dyslipidemia. Refer to dietitian or other local resources as available.

2. Explain the importance of carbohydrates (including alcohol) and their relationship to elevated triglycerides.

3. Discuss the importance of decreasing total dietary fat intake and substituting monounsaturated fats for other dietary fats.

LIP-P PREVENTION

OUTCOME: The patient/family will understand ways to prevent dyslipidemia.

STANDARDS:

1. Explain that consuming a diet low in fat and cholesterol, controlling weight, and exercising may help prevent dyslipidemia.

DYS-C COMPLICATIONS

OUTCOME: The patient will be able to relate the possible complications, the symptoms that should be reported immediately, and the appropriate actions to prevent complications.

STANDARDS:

1. Discuss the possible complications of the particular dysrhythmia, e.g. agina, stroke, CHF.

2. List the symptoms that should be reported immediately, i.e. shortness of breath, dizziness, chest pain, increased fatigue, loss of consciousness.

3. Discuss anticoagulant therapy if appropriate.

DYS-DP DISEASE PROCESS

OUTCOME: The patient will understand what the dysrhythmia is and the signs of the dysrhythmia.

STANDARDS:

1. Review the anatomy and physiology of the heart in relation to the patient's dysrhythmia.

2. Relate how the dysrhythmia occurs.

3. Describe the symptoms of the dysrhythmia.

4. List the symptoms that should be reported immediately, i.e. shortness of breath, dizziness, chest pain, increased fatigue, loss of consciousness.

DYS-EQ EQUIPMENT

OUTCOME: The patient/family will understand the proper use and care of home medical equipment.

STANDARDS:

1. Emphasize the importance of following the prescribed check up and maintenance schedule for implanted or other home equipment.

2. Explain any limitations imposed by the equipment, i.e. exposure to magnetic fields, MRIs, microwaves, etc.

DYS-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adherence to the treatment regimen and keeping appointments for follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of the dysrhythmia.

2. Explain the procedure for making follow-up appointments.

3. Review the treatment plan with the patient, emphasizing the need for keeping appointments and medication compliance.

DYS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about dysrhythmia.

STANDARDS:

1. Provide patient/family with written patient information literature on dysrhythmia.

2. Discuss the content of patient information literature with the patient/family.

DYS-M MEDICATIONS

OUTCOME: The patient will verbalize an understand the type of medication being used, the prescribed dosage and administration of the medication and will verbalize an understanding of the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication(s).

2. Emphasize the importance of maintaining strict adherence to the medication regimen and monitoring schedule.

3. Emphasize the importance of possible drug interactions with foods, drugs and over the counter medications.

DYS-TE TESTS

OUTCOME: The patient will have an understanding of the test to be performed and the reasons for the testing.

STANDARDS:

1. Explain the test(s) ordered (ECG, echo, treadmill, electrophysiological mapping, etc.).

2. Explain the indications, risks, and benefits of the test(s).

3. Explain the test as it relates to planning the course of treatment.

DYS-TX TREATMENT

OUTCOME: The patient/family will understand the therapy and the goal(s) of treatment.

STANDARDS:

1. Review the patient's medications. Reinforce the importance of knowing the drug, dose, and dosing interval of the medications, side effects, signs of toxicity, and drug interactions.

2. Emphasize the importance of maintaining strict adherence to the medication regimen.

3. Explain other treatment options as appropriate (synchronized cardioversion, transcutaneous pacemaker, transvenous pacemaker, or permanent pacemaker).

ECC-C COMPLICATIONS

OUTCOME: The parent and/or family will understand the effects and consequences of ECC on their child.

STANDARDS:

1. Review the consequences of severe tooth decay, i.e. infection, tooth loss, speech problems, aesthetics.

2. Review treatment modalities (tooth restoration, behavior management).

3. Review the health risks of general anesthesia.

4. Review the costs of extensive treatment.

ECC-DP DISEASE PROCESS

OUTCOME: The parent and/or family will understand the causes, identification, and prevention of Early Childhood Caries (ECC).

STANDARDS:

1. Review the current factual information regarding the causes of ECC.

2. Discuss how dental disease germs can be passed from parent to infant.

3. Discuss the role of sugar.

4. Review how to identify early signs of ECC.

ECC-FU FOLLOW UP

OUTCOME: The parent and/or family will understand the importance of infant and early childhood oral health care including dental well checks.

STANDARDS:

1. Discuss dental well child visits.

2. Review recommendations for early childhood dental care.

3. Discuss the importance of follow up in patients who have developed dental disease.

ECC-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent and/or family will understand that primary dentition begins to develop during fetal life and that primary teeth serve several purposes.

STANDARDS:

1. Review primary tooth development.

2. Discuss the role of primary teeth in the growth and development of the mandible, maxilla and permanent teeth.

ECC-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the ECC.

STANDARDS:

1. Provide patient/family with written patient information literature on ECC.

2. Discuss the content of patient information literature with the patient/family.

ECC-LA LIFESTYLE ADAPTATIONS

OUTCOME: The parent and/or family will understand how to avoid the disease, adopt good feeding practices, avoid falling prey to old habits and develop positive oral hygiene habits.

STANDARDS:

1. Discuss attitudes toward feeding habits.

2. Review breast-feeding and bottle feeding practices.

3. Provide information on alternatives to misuse of baby bottles, i.e. no bottles in the bed, no propping of bottles, weaning at 12 months of age.

ECC-N NUTRITION

OUTCOME: The patient/family will verbalize understanding of the need for balanced nutrition and plan for the implementation of dietary modification if needed

STANDARDS:

1. Review normal nutritional needs for optimal general and dental health.

2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits

3. Discuss nutritional modifications as related to Early Childhood Caries.

4. Emphasize the importance of adherence to the prescribed nutritional plan.

ECC-P PREVENTION

OUTCOME: The parent and/or family will understand how to prevent ECC.

STANDARDS:

1. Review adult oral hygiene with the parent.

2. Review infant/child oral hygiene, i.e. the use of a soft washcloth to clean the gums of infants..

3. Discuss methods of prevention, including fluoride supplementation and limitation of sugar in diet.

4. Explain to parents methods of early identification of dental disease in infants and small children. Explain the importance of early treatment.

5. Review proper use of and alternatives to misuse of the bottle or nipple, i.e. no bottles in bed, no propping of bottles, and weaning at 12 months of age.

6. Emphasize that nothing should be given from a bottle except formula, breast milk, water, or electrolyte solution, i.e. no juice or soda pop.

ECC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **See PM**.

2. Explain that short-term use of NSAIDS may be helpful in pain management as appropriate.

3. Explain non-pharmacologic measures that may be helpful with pain control i.e. avoid hot and cold foods.

ECC-PRO PROCEDURES

OUTCOME: The patient/family will understand procedure(s) to be performed to treat ECC and the risk of not treating ECC.

STANDARDS:

1. Explain the procedures proposed as well as alternatives and/or the risk of doing nothing.

2. Discuss common and important complications of treatment or non-treatment.

ECC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the risk(s)/benefit(s) of the test(s) and the risk(s) of refusal of the test(s).

STANDARDS:

1. Discuss the test(s) to be performed (X-ray, etc.)

2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks of non-performance of the testing.

ECC-TX TREATMENT

OUTCOME: The patient will understand the necessary treatment (filling, capping, etc.) and the proper oral care after treatment.

STANDARDS:

1. Explain the basic procedure to be used (filling, capping, etc.) and the indication, common complications and alternatives as well as the risks of non-treatment.

2. Review the specific elements of oral care after treatment. **See DC-, ECC-P**

3. Discuss the indications for returning to the provider, i.e. bleeding, persistent or increasing pain and fever.

ECZ-C COMPLICATIONS

OUTCOME: The patient/family will be able to recognize common and important complications, the symptoms should be reported immediately, and appropriate intervention(s) taken to prevent complications.

STANDARDS:

1. Discuss the possible symptoms that can lead to complications, i.e. painful dry, red skin rash that itches or is cracked, blisters, peeling, tender, or oozing skin.

2. Review the effects of skin rashes that get out of control, i.e. pain, swelling, redness, drainage, or a fever. See **SWI**.

3. Emphasize that permanent scarring or hair loss may develop if not treated early.

4. Relate that there is no cure for eczema, however, flare-ups can be treated and controlled.

ECZ-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of atopic dermatitis and eczema.

STANDARDS:

1. Briefly review the anatomy/physiology and how it relates to the protective functions of the skin.

2. Discuss that atopic dermatitis and eczema is a name given to a group of skin problems that share a pattern of changes in the surface of the skin.

3. Discuss that atopic dermatitis or eczema can begin in infancy, can last for years and can often be successfully controlled.

4. Discuss the many risk factors for eczema/atopic dermatitis including family history of asthma, food allergies, stress, and things your skin touches such as plants and animals.

5. Discuss that seasonal flare-ups are common.

6. Explain how dryness and itching can cause breaks in the skin and allow bacteria to enter the body.

7. Emphasize the importance of keeping nails cut short to help prevent breaking the skin from scratching. Bacteria is common under fingernails and can cause skin infection from scratching.

8. Discuss the importance of daily hygiene and skin inspection.

9. Explain that use of mild, non-drying, unscented soaps, avoiding very hot water and the use of moisturizing lotion or cream after bathing are all helpful. Perfumes in soaps and lotions may make eczema or atopic dermatitis worse.

10. List symptoms that need to be reported immediately: skin infection, pain, swelling, redness, a thick or colored drainage, or a fever.

ECZ-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.

2. Discuss the family's understanding of how to obtain follow-up appointments. Correct any misinformation.

3. Emphasize the importance of keeping follow-up appointments.

ECZ-L PATIENT INFORMATION LITERATURE

OUTCOME: The family/patient will receive written information about eczema/ atopic dermatitis.

STANDARDS:

1. Provide family/patient with written patient information literature about eczema/atopic dermatitis.

2. Discuss content of the patient information literature with the patient/family.

ECZ-M MEDICATIONS

OUTCOME: The patient/family will understand the importance of compliance with the prescribed medication regimen.

STANDARDS:

1. Discuss the reason for specific medication, treatment, and environmental changes needed to treat this patient's condition.

2. Review directions for use of medication and duration of therapy.

3. Discuss expected benefits of therapy and the important and common side effects.

4. Discuss warning signs to report to the doctor.

5. Discuss the importance of strict compliance with medication regimen.

6. Advise that both topical and oral medications can trigger a skin reaction like hives or sunburn. Warn to be alert for any reactions to new medications. Advise patient/family to call a provider to get a substitute medication if a reaction occurs.

7. Emphasize the importance of follow-up.

ECZ-N NUTRITION

OUTCOME: The patient/family will understand nutritional factors that may effect atopic dermatitis or eczema.

STANDARDS:

1. Discuss that some foods may effect atopic dermatitis or eczema. Common triggers are milk products, egg products or wheat products.

2. Refer to a dietician as appropriate.

ECZ-P PREVENTION

OUTCOME: The patient/family will understand the appropriate measures to prevent eczema and atopic dermatitis flare-ups.

STANDARDS:

1. Discuss that breast-fed infants are less likely to develop atopic dermatitis or eczema.

2. Discuss avoiding exposure to extreme temperatures, dry air, pet danders, harsh soaps, and bubble baths.

3. Consider the use of cotton blankets and clothing, rather than more irritating fabrics such as wool, or stiff synthetics like polyester.

4. Explain the importance of good hygiene and protection of skin by patting dry after shower or bath to leave some moisture on the skin. Instruct to apply a moisturizing cream, lotion or ointment immediately after bathing to retain moisture in the skin.

5. Explain that skin care products which contain alcohol, perfumes, dyes or allergens may actually worsen the condition.

6. Discuss the importance of avoiding skin contact with irritating chemicals, plants, jewelry, and other substances that trigger skin allergies and dermatitis.

7. Explain that a room humidifier will add moisture to indoor air during the winter heating season.

ECZ-WC WOUND CARE

OUTCOME: The patient/family will have an understanding of the necessity and procedure for proper wound care and infection control measures. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the rationale for appropriate care to the wound, ie, decreased infection rate, improved healing, etc.

2. Demonstrate and explain the correct procedure for caring for this patient's wound. Ask for a return demonstration if needed.

3. Describe signs and symptoms that would require immediate follow-up, ie, increasing redness, purulent discharge, fever, increased swelling, or pain, etc.

4. Detail the supplies necessary for care of this wound and how/where they may be obtained and the proper methods for disposal of contaminated supplies.

5. Emphasize the importance of follow-up.

ELD-DP DISEASE PROCESS/AGING

OUTCOME: The patient/family will have an understanding of the normal aging process and will develop an action plan to maintain optimal health while aging.

STANDARDS:

1. Explain the normal anatomy and physiology of the aging process.
   a. it is normal to slow down as one ages
   b. some lapses in short-term memory are common
   c. some decrease in sex drive and ability to perform are common
   d. changes in sleeping patterns are common
   e. presbyopia (far sightedness) is nearly universal as humans age

2. Explain that older individuals often have several chronic diseases that may need special attention in light of their advanced age.

3. Depression is common and may be difficult to diagnose. Family and caregivers should be :instructed to watch for signs of depression, i.e. loss of appetite, social withdrawal, etc.

ELD-EX EXERCISE

OUTCOME: The patient/family/caregiver will understand that continued physical activity may offset some common problems of aging.

STANDARDS:

1. Explain the importance of physical activity in maintaining health.

2. Emphasize the importance of evaluation by a physician prior to starting a new exercise program.

3. Discuss recommended activity level including any restrictions on activity.

4. Explain that chest pain experienced during exercise should be immediately evaluated by a health care provider.

ELD-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand their responsibility in health maintenance and the importance of keeping follow-up appointments.

STANDARDS:

1. Explain the procedure for obtaining follow-up appointments.

2. Emphasize the importance of keeping appointments.

3. Discuss the importance of bringing all medications to each visit.

4. Stress the importance of compliance with the health maintenance plan between visits.

5. Emphasize the importance of regular health screening for older adults, i.e. colonoscopy, mammograms, pap smears, PSAs, etc.

6. Refer to community resources as appropriate, i.e., meals on wheels, elder transportation vans, medicare, etc.

ELD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family caregiver will receive written information about aging or elder health care issues.

STANDARDS:

1. Provide the patient/family/caregiver with written patient information about aging or elder health care issues.

2. Discuss the content of the patient information literature with the patient/family/caregiver.

ELD-LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient/family/caregiver will have an understanding of the lifestyle adjustments needed to maintain optimal health and will develop a plan o modify behavior where needed.

STANDARDS:

1. Assess the patient/family/caregiver level of understanding and acceptance of the aging process.

2. Refer to Social Services, Mental Health, Physical Therapy, Rehabilitative Services and/or other resources as appropriate.

3. Review the lifestyle areas that may require adaptations: diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships, transportation issues, isolations issues, etc.

ELD-M MEDICATIONS

OUTCOMES: The patient/family/caregiver will develop a plan for the patient taking prescribed medications correctly.

STANDARDS:

1. Review the patients medication regimen.

2. Suggest techniques to ensure that medications are taken correctly, i.e., weekly medicine dispensing boxes, written lists, etc.

3. Emphasize the importance of taking all medications to each visit.

4. Emphasize the importance of medication compliance.

5. Consider community health nursing referral to assess the elder patient's ability to comply with taking their medications correctly, as appropriate.

ELD-N NUTRITION

OUTCOME: The patient/family/caregiver will understand dietary requirements for optimal health in this patient.

STANDARDS:

1. Assess nutritional status using 24-hour diet recall or other tool.

2. Discuss this patient's specific nutrition plan.

3. Identify problems such as dental or gum disease, financial limitations, cognitive limitations or other conditions which may limit the patient's ability to achieve good nutrition. Refer as appropriate.

ELD-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family/caregiver will understand the importance of injury prevention and make a plan to implement safety measures.

STANDARDS:

1. Explain the importance of body mechanics in daily living to avoid injury, i.e. proper lifting techniques.

2. Assist the patient/family/caregiver in identifying ways to adapt the home to improve safety and prevention injuries (remove throw rugs, install bars in tub/shower, secure electrical cords, install ramps, etc.)

3. As appropriate, stress the importance of mobility assistance devices such as canes, walkers, wheel chairs, therapeutic shoes, etc.

4. Discuss the current/potential abuse of alcohol or drugs.

5. Emphasize the importance of NEVER smoking in bed. Refer to smoking cessation programs as appropriate.

6. Discuss the potential for elder abuse/neglect (including financial exploitation) and ways to identify abuse/neglect. Refer as appropriate.

EOL-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms and prognosis of his/her illness.

STANDARDS:

1. Explain the basic anatomy and physiology of the patient's disease and the effect upon the body system(s) involved.

2. Discuss signs/symptoms of worsening of the patient's condition and when to seek medical care.

EOL-EQ EQUIPMENT

OUTCOME: The patient/family will verbalize understanding and demonstrate (when appropriate) proper use and care of medical equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed medical equipment to be used during the hospital stay and after discharge. as appropriate.

2. Discuss and/or demonstrate proper use and care of medical equipment, including safety and infection control principles.

3. Assist in return demonstration by patient/family.

EOL-GP GRIEVING PROCESS

OUTCOME: The patient/family will understand the grieving process, recognize the sense of loss, and embrace the importance of preparing for the end of life emotionally and spiritually.

STANDARDS:

1. Explore the various losses and feelings that affect the patient and his/her loved ones when faced with a terminal illness. Explain that grief and a sense of loss become more intense when a patient is dying.

2. Discuss fears, myths and misconceptions of the dying process with the patient and family.

3. Discuss the importance of keeping open communication and promoting social interaction in preserving the dignity of the patient.

4. Explain that the five major losses experienced by a dying patient are; loss of control, loss of identity, loss of achievement, loss of social worth, and loss of relationships.

5. Explore how separation and mourning are aspects of the bereavement process.

6. Explain that bereavement coincides with the patient's imminent death and continues through the actual death event and the period of time immediately thereafter.

7. Explain that the need to repeatedly verbalize feelings is a normal part of grieving.

EOL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the patient's specific disease process, hospice care, end of life issues, advanced directives, support groups or community resources as appropriate.

STANDARDS:

1. Provide patient/family with written patient information literature.

2. Discuss the content of the patient information literature with the patient/family.